LETTERS

Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

The permissible use of placebo

Whilst we agree with Professor Ernst that there is scant original research supporting the use of the placebo test (*JRSM* 2007;**100**:165),[1] we maintain that it is useful. Provocation, cessation or amelioration of seizures[2] and movement disorders[3] with placebo use is often a diagnostic criterion (amongst others) for psychogenic disease. In addition, placebo therapy has been used to treat psychogenic diseases.[3]

Our work highlighted the potential diagnostic or therapeutic benefits of placebo use whilst emphasizing the ethical concerns mitigating against its casual use (*JRSM* 2007;**100**:60–61),[4] but we acknowledge its potentially deceptive nature.[1,2] We advocate that physicians managing patients with psychogenic disease practice knowledge framing,[4] providing a neurobiological explanation for the disease, including the possibility of a psychological basis for the patients' attacks.[2] As doctors are not averse to using placebos[5]—even while they publicly decry them—we feel that it is timely that we reach a consensus on the acceptability and utility of placebo use.

Competing interests None declared.

Erle C H Lim[1,2] and Raymond C S Seet[1,2]
[1]Yong Loo Lin School of Medicine, National University of Singapore
[2]National University Hospital, Singapore
Email: erlelim@nus.edu.sg

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Resources could be spent better than on saving children

Most doctors who have worked in Africa will agree with the late Imre Loefler that the preferential treatment of children is misplaced (*JRSM* 2007; **100**: 110–111). In fact, I wrote a piece in 1983 entitled '*Should Charity always begin with Children?*', which pleaded for more help for women with vesico-vaginal fistulae. But incontinent women are not as photogenic as wide-eyed children and, as fundraisers well know, rational argument rarely wins over emotion.

I found the avoidable deaths of young adults much harder to take than the high child mortality for two reasons. My first reason is that the best security for a child in Africa, where the welfare state is rudimentary, is to have two healthy parents. My second reason will be considered more controversial, but I came to realise that some of the children who returned to my clinic time after time were not meant to live. In a survey of 1200 consecutive admissions to the children's ward, done primarily to assess the effect of measles vaccine, the mortality was 21.5%, and of those 77.7% died with 24 hours of admission. In an area where abortion was unthinkable and Children's Homes a rarity, unwanted babies just faded away. Even in this rich country a judgement has to be made about the allocation of resources, and that is even more important in Africa.

Competing interests None declared.

Anne Savage
7 Akenside Road, London NW3 5RA, UK
Email: anne@savage2303.freeserve.co.uk

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Cost to the NHS of Roche oncology treatments

Dr Atkins[1] defends the usual practice of pharmaceutical companies of underestimating the costs of the administration of their products in the media (*JRSM* 2007;**100**:303). As we all know, the NHS has great difficulty in working out the true cost of any component of care as its accounting and IT systems are primitive. My figures[2] were obtained simply by determining the costs to a self-pay private patient in London over a one-year period. These costs are actually very similar in the private sector and NHS. As most patients obtain non-NICE approved cancer drugs outside the NHS, this seems the fairest way to make the calculation.

I would strongly dispute Dr Atkins' claim that the non-drug costs to administer adjuvant trastuzumab—which requires at least 30 visits a year for intravenous drug administration by skilled nurses, cardiac monitoring, side effect management, disease assessment and consultant supervision—amount to only £3,580. Medical care just

doesn't come that cheap, even in the NHS. In an era when patients are now having to pay supplements for innovative drugs for cancer it is vital that we make the total cost of exercising this choice crystal clear.

Competing interests None declared

Karol Sikora
Medical Director, CancerPartnersUK, 21 Barrett Street, London W1U 1BD, UK
Email: Karol.Sikora@cancerpartnersuk.org

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The Royal College of Surgeons

I was delighted by the paper by Maynard and Ayalew on the Royal Colleges of Medicine and Surgery and its up-to-date list of the Colleges (*JRSM* 2007;**100**:306–308).[1] But there is one mistake in the list; a mistake so trivial that it I mention it only because it conceals an interesting story. The Royal College of Surgeons founded in 1800 was the Royal College of Surgeons of *London*, not the Royal College of Surgeons of *England*.

With the rapid growth of hospitals in the second half of the eighteenth century, the contribution of the physicians in treating medical diseases was very slight. But the surgeons provided a genuinely helpful surgical service, based largely on the treatment of accidents. For this reason, the status of surgery rose very rapidly and the London hospital surgeons saw themselves as the 'top dogs'—hence the foundation of the Royal College of Surgeons in 1800 and the right to put 'MRCS' after their names.

Fifteen years later, newly qualified general practitioners had to obtain the Licence of the Society of Apothecaries and earned the right to put LSA after their name; but a majority also took the MRCS, so that the hallmark of the typical general practitioner was the possession of the MRCS and the LSA, colloquially known as 'College and Hall'. That is where the trouble began.

The last thing the hospital surgeons wanted was to be confused with the general practitioners, whom they heartily despised. Sharing the MRCS was out of the question, so the hospital surgeons obtained a charter in 1843 which enabled them to introduce the Fellowship (FRCS) as the hallmark of the 'pure surgeon'. Fellows of the College of Surgeons refused to have any involvement in midwifery and pharmacy, because both played a large part in general practice, and insisted that only Fellows could use the front door of the London College; general practitioners had to go round the back. For the first few years after 1843 fellowships were handed out, without any examination, to the surgeons chosen by Council. Nepotism was rife. As an additional display of their superiority they expanded their territory, re-naming their College as the Royal College of Surgeons of England. This is where and when the routine denigration of general practice by hospital consultants began.

Competing interests None declared.

Irvine Loudon
Medical Historian
Email: Irvine.loudon@green.ox.ac.uk

REFERENCE

1 Maynard A, Ayalew Y. Performance management and the Royal Colleges of Medicine and Surgery. *J R Soc Med* 2007;**100**:306–8

Patient-reported outcome measures

In their recent essay (*JRSM* 2007;**100**:306–8), Maynard & Ayalew referred to the absence of patient reported outcome measures (PROM). They should have been aware that the Royal College of Surgeons of England, with the London School of Hygiene and Tropical Medicine, carried out a project to establish the feasibility of applying PROM for elective surgical procedures. The final report in June 2007 recommended specific measures that are going to be used as part of an audit we are undertaking with the Department of Health relating to surgical outcomes in Independent Sector Treatment Centres (ISTCs). We expect to publish our preliminary findings in 2010. Far from ignoring this vital area of assessment, we have shown leadership by employing this research tool to resolve preconceived attitudes about care in ISTCs.

Maynard & Ayalew referred also to the NHS subsidizing Royal Colleges by releasing consultants for examination and other duties. It is not the Colleges that benefit by this arrangement, but the NHS and its patients, as those involved in teaching, training and examining are helping to ensure high standards of care in the future. My College's examiners are not paid a fee and I doubt that the population generally would criticize this use of their time. Professor Maynard has a direct interest in this issue as the Chairman of a Foundation Trust and I wonder whether his interest has been declared.

Competing interests None declared.

Bernard Ribeiro
President of the Royal College of Surgeons of England
Email: president@rcseng.ac.uk

REFERENCE

1 Maynard A, Ayalew Y. Performance management and the Royal Colleges of medicine and surgery. *J R Soc Med* 2007;**100**:306–8

Convictions in sexual assault cases

Beata Cybulska (*JRSM* 2007;**100**;321–324) has given a valuable insight into aspects of sexual assault, especially with respect to the low conviction rate for rape.

I am frequently called on to assess the validity of DNA data and analytical evidence for alcohol and drugs in such cases. Regrettably, it is clear that the low conviction rate occurs for a variety of reasons, not least the delay in the

victim making a complaint to the police. But even with fairly rapid responses, cases fail for the following reasons:

(1) The victim has washed or destroyed items of clothing or bed linen;
(2) The victim has bathed or showered following the assault;
(3) The victim was too intoxicated to remember many significant details of the events that occurred.

A very important point that must be considered is that after being sexually assaulted and/or raped the victim often feels traumatized, debased, contaminated and unclean and may develop a pathological desire to remove and wash away the effects and feelings from the sexual encounter. In many respects any significant increase in convictions for sexual assaults and rapes will only come about if it is possible to get the message across and widely accepted that women and men who are subjected to such offences should: complain quickly to the police, not wash or bathe before being medically examined, retain all items of clothing and bed linen, and try to provide as much fine detail about the assailant, the venue and the circumstances as possible.

That is asking a great deal from a person who has undergone such an indignity, but the greater the information available the better the chance of a conviction being possible.

Competing interests RCD is visiting Professor in Forensic Science at Kingston University and is an independent consultant forensic scientist.

Professor Ronald C Denney
Manteo, 8 Letter Box Lane, Sevenoaks, Kent TN13 1SN, UK
Email: ronald.denney@virgin.net

REFERENCE

1 Cybulska B. Sexual assault: key issues. *J Roy Soc Med* 2007;**100**:321–4

Fleiss, Freud and the nose

The review by Mahmood Bhutta (*JRSM* 2007;**100**:268–274) concludes that, even in humans, the humble nose maybe responsible for far-reaching consequences if it cunningly influences one's choice of partner.[1] Grand claims have previously been made for this appendage. Wilhelm Fleiss (1858–1928), a nose and throat specialist in Berlin, developed a unique and curious theory that illnesses are caused by disturbances in the nasal mucous membranes.[2]

Fleiss attended a course of lectures given by Sigmund Freud in Vienna and they later became close and influential friends;[3] indeed, Fleiss twice operated on Freud's nose. In 1893 Fleiss published his monograph on 'The Nasal Reflex Neurosis', in which he claimed that back pain, chest tightness, digestive disturbances, insomnia and 'anxious dreams' could all be attributed to nasal pathology. He also claimed that temporary relief of these symptoms was possible with the topical application of cocaine,[4] of which Freud had published the first account of local anaesthetic properties.[5]

Gradually the list of conditions grew to include migraine, vertigo, asthma and then gynaecological conditions such as dysmenorrhoea and repeated miscarriages. All these could be diagnosed by careful inspection of the nasal mucosa. Fleiss later concluded that there was a 'special' connection between the nose and the sexual organs.

It is interesting that recent and more orthodox research techniques have confirmed a link of sorts and possibly a subliminal reflex between the nose, its olfactory function and choice of sexual partners. A limited degree of posthumous credibility might now distinguish Fleiss and his once-discredited nasal-reflex theory.

Competing interests None declared.

Dr Peter Perkins
Southbourne Surgery, 17, Beaufort Road, Bournemouth BH6 3LF
Email: peter.perkins@dorset.nhs.uk

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Connections with death

I read Dr Abbasi's recent From the Editor (*JRSM* 2007;**100**:205) with some interest, especially the reference to the late Dr Robert Volpe, a member of the Journal's Editorial Advisory Board, whom I knew when working at the Toronto General Hospital in the late 1950s and who died in April 2005. I believe that Fellows would be interested to know a little of the achievements of this long-standing member of the Advisory Board.

He was an internationally renowned endocrinologist and researcher, the first to highlight the role of specialized cells of the immune system in thyroid disease, and was instrumental in establishing the Canadian Society of Endocrinology and Metabolism. In 1996 he gave the celebratory lecture commemorating the 200th anniversary of the birth of Robert Graves in Dublin. He was on the staff of several of Toronto's university hospitals as Professor of Medicine for many years. A Fellow of the Royal College of Physicians and Surgeons of Canada for nearly 50 years, he was elected their Vice-President of Medicine, and in 2003 he was named an Officer of the Order of Canada, the country's highest honour for lifetime achievement. He was predeceased by his wife and survived by his four children.

Competing interests None declared.

P I Reed
Retired Consultant Physician and Gastroenterologist
Email: Pireed@aol.com

REFERENCE

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